The Status of

Sexually Aggressive Youth

in

North Carolina

1997-1998

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A Report by the
North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Child and Family Services Section

The Status of Sexually Aggressive Youth in North Carolina 1997-1998

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The Status of Sexually Aggressive Youth in North Carolina 1997-1998

> *"Thus, one completely inappropriate response to a youth who has demonstrated sexually aggressive behavior is to do nothing about it, to ignore it, not to demand accountability and responsibility from him for his actions. An equally inadequate response is to incarcerate the youngster with no provisions for treatment, expecting that somehow punishment will teach him a lesson and the behavior might stop. Other common, but unsatisfactory, responses include sentencing the youngster without benefit of a competent clinical assessment by an experienced sex-offender evaluator, or sentencing the offender to traditional non-specialized therapy in whatever type of program happens to be available, regardless of his placement needs." (Knopp, 1996)*

Background

In recent decades, mental health and criminal justice professionals have become increasingly concerned about the number of children and adolescents involved in sex offenses, both as perpetrators and victims. It is estimated that approximately 50% of adult sex offenders report that they participated in sexually deviant behavior in adolescence (Abel et al., 1985; Becker & Abel, 1985; Longo & Groth, 1983; Groth et al., 1982). Incarcerated adult offenders, in another study, admitted to committing up to five times as many sexual offenses as those for which they were apprehended and admitted committing their first offenses as early as eight and nine years of age (Knopp, 1996).

While the incidence of adolescent sex offenses continues to be underreported in official statistics, there is increasing awareness of the extent of the problem and the need for early specialized therapeutic intervention. Specialized community-based treatment, provided at the earliest recognition of the problem or at the time of first legal involvement, is much less expensive and will yield more positive results than later institutional treatment for more serious offenses (Knopp, 1996).

As a result of the increased number of referrals from the courts to the Area Mental Health, Developmental Disabilities and Substance Abuse Programs (Area Programs) for Sex Offender Specific Evaluations and treatment, it became apparent in the 1980's that North Carolina needed a specialized treatment program for Youthful Sex Offenders. The Division of Mental Health, Developmental Disabilities and Substances Abuse Services (MH/DD/SAS) began to focus specialized services on the youthful sex offender

population in 1986 by establishing four small pilot programs through grants in each of the four mental health regions of the state. With these grants, the four programs planned, developed and implemented community based diagnostic and treatment services for the YSO population. On-going training opportunities sponsored by the Division of MH/DD/SAS augmented the work in the pilot programs and began the process of developing a treatment capacity in the other 37 Area Programs.

Effective July 1, 1994, the term "Youthful Sex Offender" was changed to "Person with a Sexually Aggressive Behavior Problem" or Sexually Aggressive Youth. A "person with a sexually aggressive behavior problem" is defined as ***an individual who: (a) admits to having committed an act of sexual abuse or has been adjudicated of an illegal sexual act AND (b) the inappropriate sexual behavior is a current focus of treatment.*** This revised definition broadened the target population to include both adjudicated and non-adjudicated youth and placed the focus of treatment on the presenting problem (inappropriate sexual behavior) rather than on strict reliance on adjudication.

In 1993, 1996, and in March 1999, the Area Programs were surveyed on the profiles of Sexually Aggressive Youth and the status of services provided to those who were identified as Sexually Aggressive Youth. The Area Programs were asked to submit the information on the document provided in Attachment 2. All 40[1] Area Programs completed and returned the survey.

The development of the 1996 and 1998 surveys was a joint effort by the Child and Family Services Section of the Division of MH/DD/SAS and the Sexually Aggressive Youth Task Force. The task force is comprised of Area Program child mental health staff that work directly with the sexually aggressive youth population. This group provides leadership and direction to regional practitioner networks as well as input and feedback to the Child and Family Services Section regarding policy formulation, training needs of practitioners, and the status of the target population.

SUMMARY OF FINDINGS

Comparison of 1993, 1996 and 1998 Sexually Aggressive Youth Survey Results

The 1998 Sexually Aggressive Youth Survey was designed to gather specific information regarding the demographic make-up of the target population, the array of treatment services available for these youth, the level of need that characterizes the population, and the barriers to treatment found by the Area Programs. Comparison of the results of the current (1998) and previous (1996 and 1993) surveys is found in Table 1. Of greatest concern is the continued growth of the total sexually aggressive youth population increasing by 46% over the last five years.

Table 1. A Comparison of the Numbers of Sexually Aggressive Youth in Treatment

[1] In 1998, the number of area programs changed from 41 to 40 through consolidation.

	1993 Survey Results	1996 Survey Results	1998 Survey Results	% of Change 1993-1996	% of Change 1993-1998
Age 7-11	146	198	212	35.7%	45.3%
Age 12-18	619	625	904	00.1%	46.1%
Male	688	767	1,011	11.5%	47.0%
Female	77	56	105	-37.5%	36.4%
Total Served	**765**	**823**	**1,116**	**7.6%**	**45.9%**

Description of the Population

Figures 1 through 4 depict the Sexually Aggressive Youth population in regard to gender, age, race, Sex Offender Specific Evaluation's (SOSE's) conducted, court involvement, numbers of adjudicated, and presence of accompanying developmental disability. Figure 1 depicts the gender composition by percentages.

Figure 1. Male and Female Sexually Aggressive Youth from All Age Categories

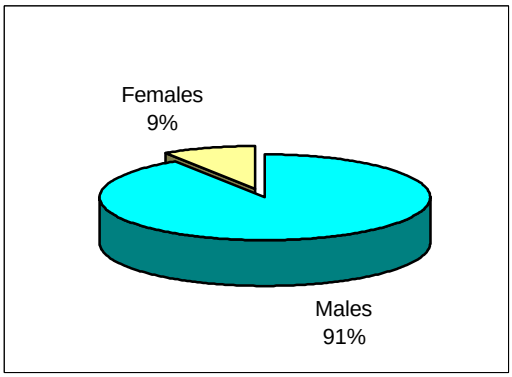
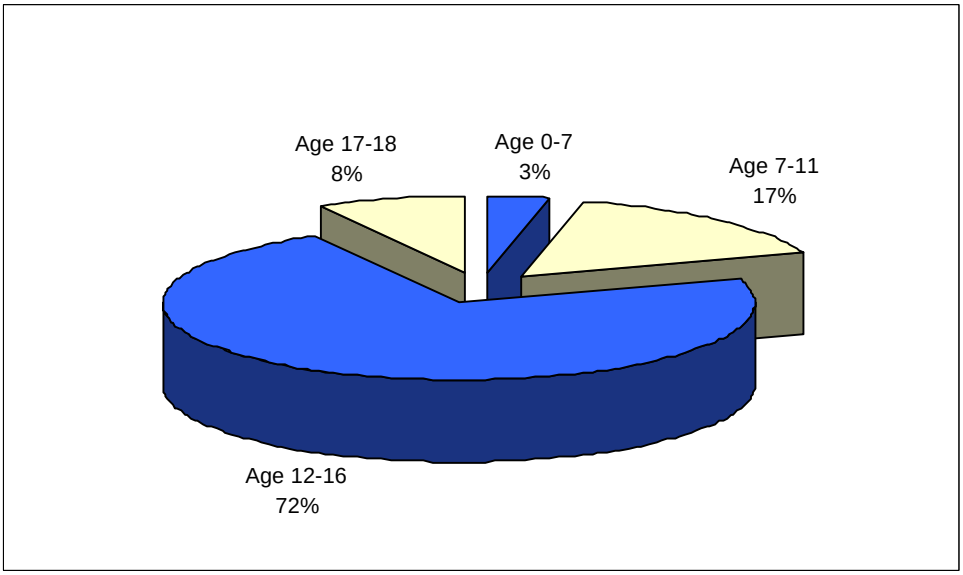


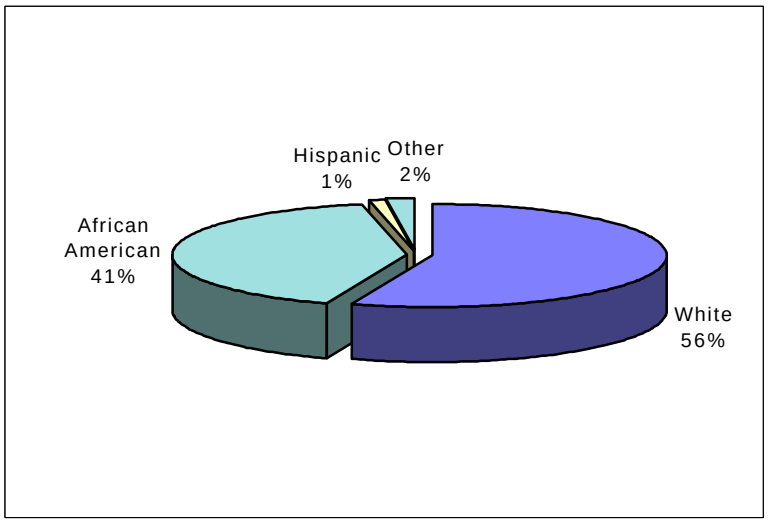
Figure 2 provides a representation of the population based upon four distinct age groupings. While there has been an increase from 1996-1998 in the number of youth with sexual aggressive problems between the ages of 0-11, it is important to note that 80% of these youth range in ages of 12-18.

Figure 2. Age Distribution of Sexually Aggressive Youth



The percentage of youth by race is represented in Figure 3. The category of "Other" includes individuals of Asian decent, Native American Indians, and any additional racial/ethnic categories not specifically identified in the survey.

Figure 3. Sexually Aggressive Youth Identified by Racial / Ethnic Categories

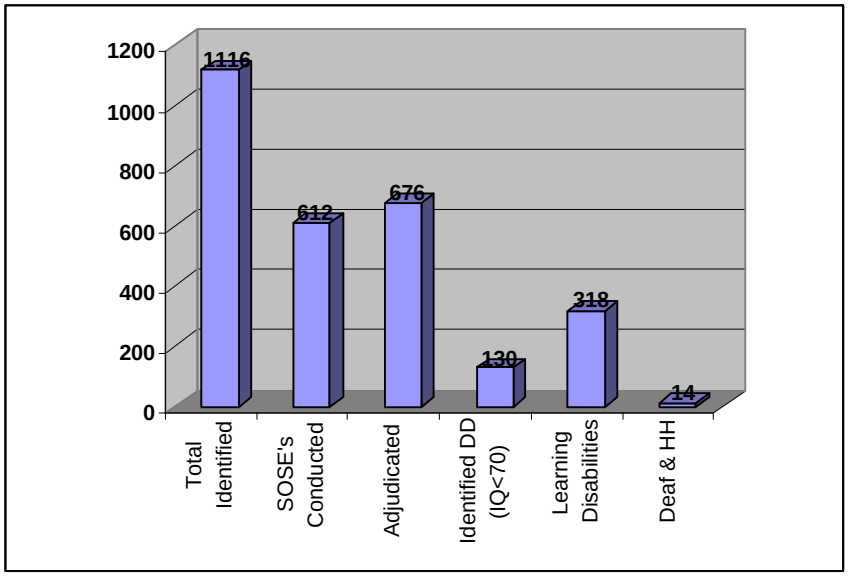


Various categories of youth with sexually aggressive behavior problems in relation to the total number of youth within this population are represented in Figure 4. Note that nearly 61% of Sexually Aggressive Youth were adjudicated; 12% were identified with developmental disabilities; another 28% were reported to have learning disabilities, while 1% of those in treatment were deaf and/or hard of hearing. While Area Programs report that they had 14 deaf and hard of hearing youth in treatment, Regional Coordinators for the Deaf and Hard of Hearing report a need for residential treatment for 25 deaf/hard of hearing youth.

There were 1,116 Sexually Aggressive Youth identified statewide for Fiscal Year 1997-1998. Of the youth identified, Sex Offender Specific Evaluations (SOSE's) were conducted on 612 (55%) of them. SOSE's are evaluations that are conducted by specially trained mental health practitioners. These extensive evaluations are used to gain important background information regarding the youth's inappropriate sexual behavior, evaluate the general dangerousness of the youth, and estimate the risk for re-offending. This evaluation is used to ascertain any threat the sexually aggressive youth may pose to the community and to provide recommendations to the court regarding the most appropriate treatment and placement.

It should be noted that the total number of youth with sexual aggressive behavior problems in the general population is probably greater than the 1,116 the survey reports. There is no way to account for the likely number of youth who were not referred because of limitations in the capacity of the Area Programs to provide the service. Undoubtedly there are a number of youth that also went unidentified.

Figure 4. Youth with Sexual Aggression Behavior Problems Identified by Various Categories



Sexually Aggressive Youth Evaluated as Low, Moderate and High Risk

For the purpose of this survey, Sexually Aggressive Youth's risk categories were defined using three general criteria which indicate the youth's most appropriate (1) living arrangement, (2) level of supervision, and (3) intensity of treatment. The following definitions provided the guidelines for Area Programs to complete the survey.

Low-risk offenders: typically remain in the home, require lower levels of supervision and can be treated with low intensity outpatient treatment services. In certain cases where the youth poses a threat to other siblings, the youngster may be temporarily placed outside the home.

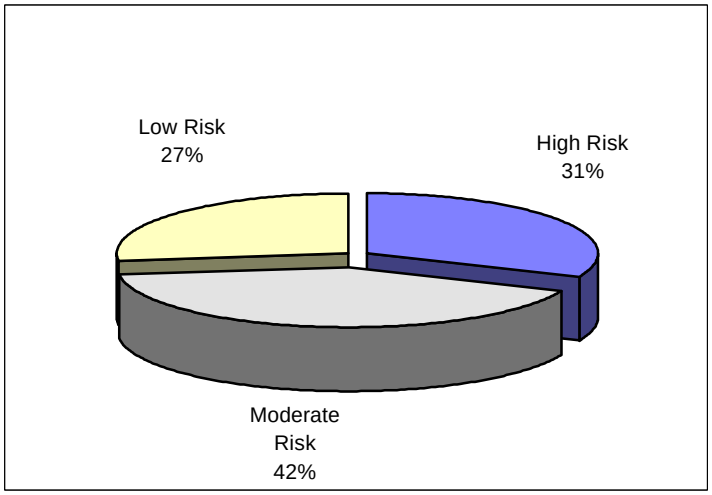
Moderate-risk offenders: may receive community-based treatment in an alternative living situation with on-going supervision and intensive treatment services provided on an outpatient basis. Because of the potential risk this grouping may be to the community,

some may require more intensive treatment and supervision provided for in a residential treatment setting.

High-risk offenders: typically require a locked, secure setting which provides around the clock supervision and treatment services provided in that setting. This group may also require a step-down placement to a less restrictive residential treatment before returning to the natural family setting.

Figure 5 provides a representation of how sexually aggressive youth were distributed across the three risk categories. It should be noted that at least 31% require a restrictive setting with another 42% posing a significant threat to community safety if supervision and intensity of treatment is compromised.

Figure 5. Youth with Sexual Aggression Problems Evaluated as Low, Moderate and High Risk



Offenses and Victims Disclosed by Sexually Aggressive Youth

A total of 3,456 separate offenses were reported by the youth to their mental health providers. This figure does not represent the number of offenses committed during the year, but rather the number of offenses *disclosed* during the year. *This averages to approximately 3.1 offenses per sexually aggressive youth.* **Research indicates that the average adolescent sex offender will, without treatment, commit 380 sexual crimes during his lifetime.** (Abel et al, 1984)

Similarly, the total number of different victims disclosed by the youth was 1,046. Again, this number represents the number of victims disclosed by the youth to their mental health

provider during the last year. *This averages to approximately 1.1 victims for each youth identified.* The number of victims, as expected, increases with the age of the youth. Figure 6 represents the number of offenses and victims disclosed by youth with sexual aggressive behavior problems, both at assessment and during the course of treatment.

Figure 6. Offenses and Victims Disclosed by Youth with Sexual Aggression Problems

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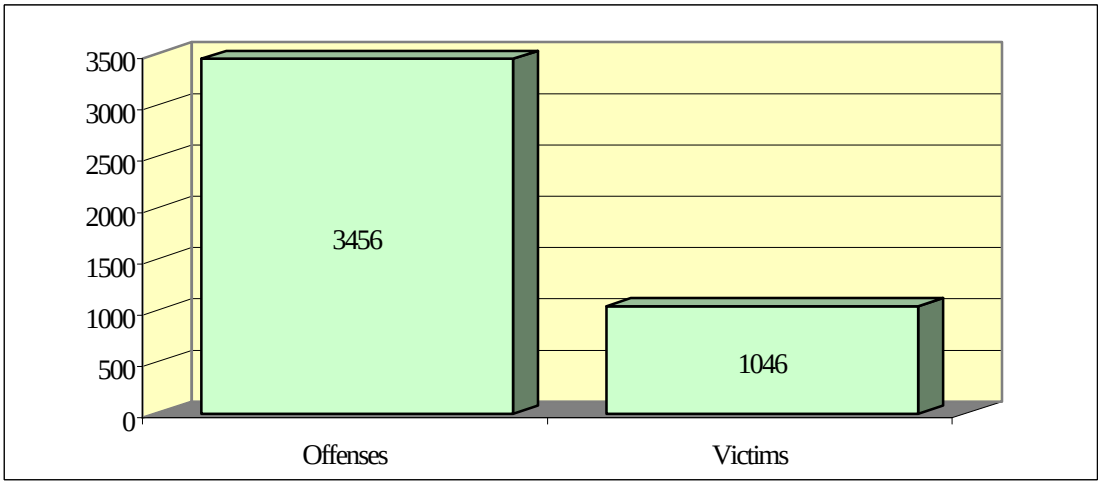
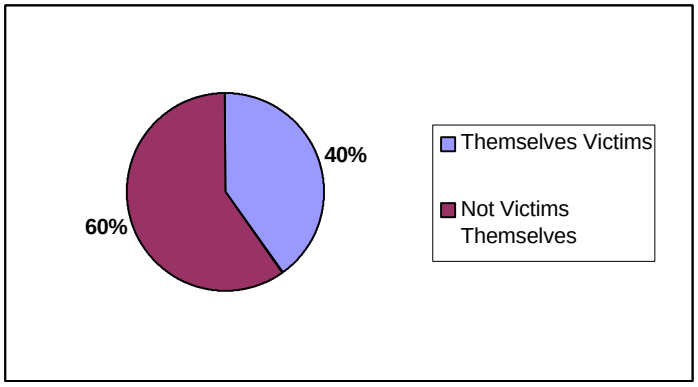


Of the 1,118 youngsters in treatment, 449 (40%) reported to their treatment provider that they were victims of sexual abuse as well.

Figure 7. Perpetrators who Themselves Were Victims of Sexual Abuse



Services Provided as Treatment to Sexually Aggressive Youth

Following the Sex Offender Specific Evaluation, most sexually aggressive youth begin treatment with an Area MH/DD/SAS Program. There is a wide array of treatment

services available for youth with sexual aggression problems. Statewide some variability exists due to limited resources among Area Programs in their ability to provide a continuum of services. Table 2 reflects the statewide variability associated with serving children who are sexually aggressive across the four mental health regions.

Table 2. Penetration Rate per 10,000 in the Population Ages 0-17 Who Receive Services through Area Programs in the Four Regions of the State.

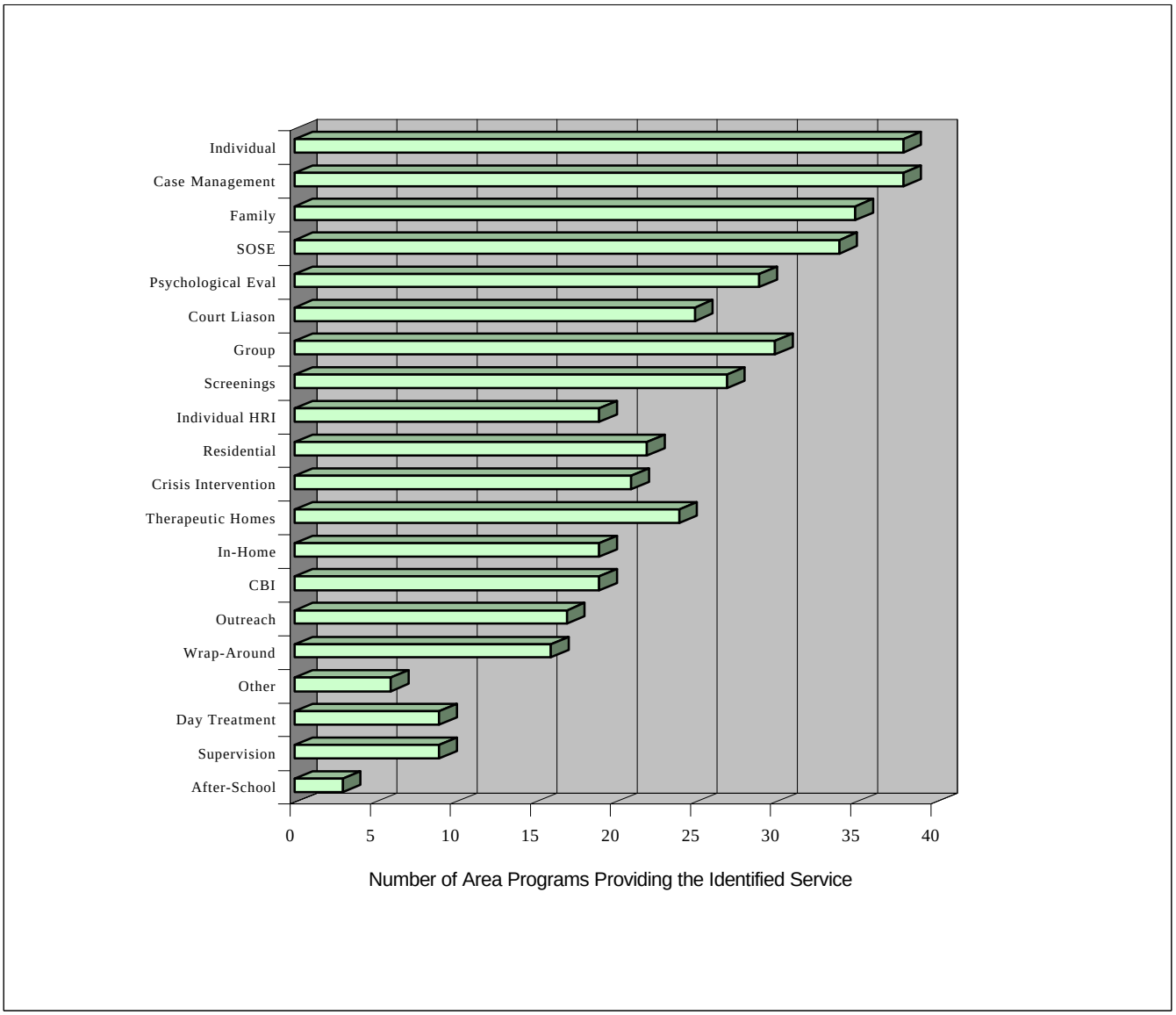
Region	**Number of YOUTH Treated**	**Pop 1998 (0-17)**	**Rate per 10,000 who received treatment**
Western	470	610,106	7.7
N. Central	228	368,499	6.2
S. Central	242	461,294	5.2
Eastern	176	379,662	4.6
TOTAL	1,116	1,819,561	6.1

Research findings support the use of group therapy as the primary mode for treating sex offenders. Seventy-five percent of the Area Programs provide group therapy to youth with sexual aggressive problems on a weekly basis. These groups are typically conducted with two trained mental health practitioners and 70% of the groups are led jointly by male/female co-therapists.

The array of treatment services provided to sexually aggressive youth is shown in Figure 7. Individual therapy was provided in almost 95% of the programs. Case management services were also provided 95% of the time, and family therapy, 88% of the time. The majority of services represented in Figure 8 reflect efforts by the Area Programs to serve these special youth in the least restrictive setting that is appropriate to their needs while providing for the safety of the community.

Frequently, a combination of treatment services is delivered to address the needs of this group of youngsters. For example, a youth with a moderate risk to re-offend might receive group and family therapy one time per week as well as case management and individual high-risk intervention (wrap-around) services. In some Area Programs this same youth would have access to crisis intervention services and an in-home worker on an "as needed" basis. A brief definition of the services identified in Figure 8 is provided in Attachment 2.

Figure 8. Services Provided as Treatment to Youth with Sexual Aggression Problems



Even though there is a wide range of services available, it is significant that 38 of the 40 area programs listed the unavailability of specific residential treatment as a barrier to effective service delivery. It was reported in the survey that of the Sexually Aggressive Youth in treatment, approximately 593 of them (all the high risk offenders and at least 1/3 of moderate risk offenders) required high intensity sexually aggressive youth specific residential treatment and supervision. In North Carolina there are 38 spaces available to specifically treat this population in a residential mental health setting.

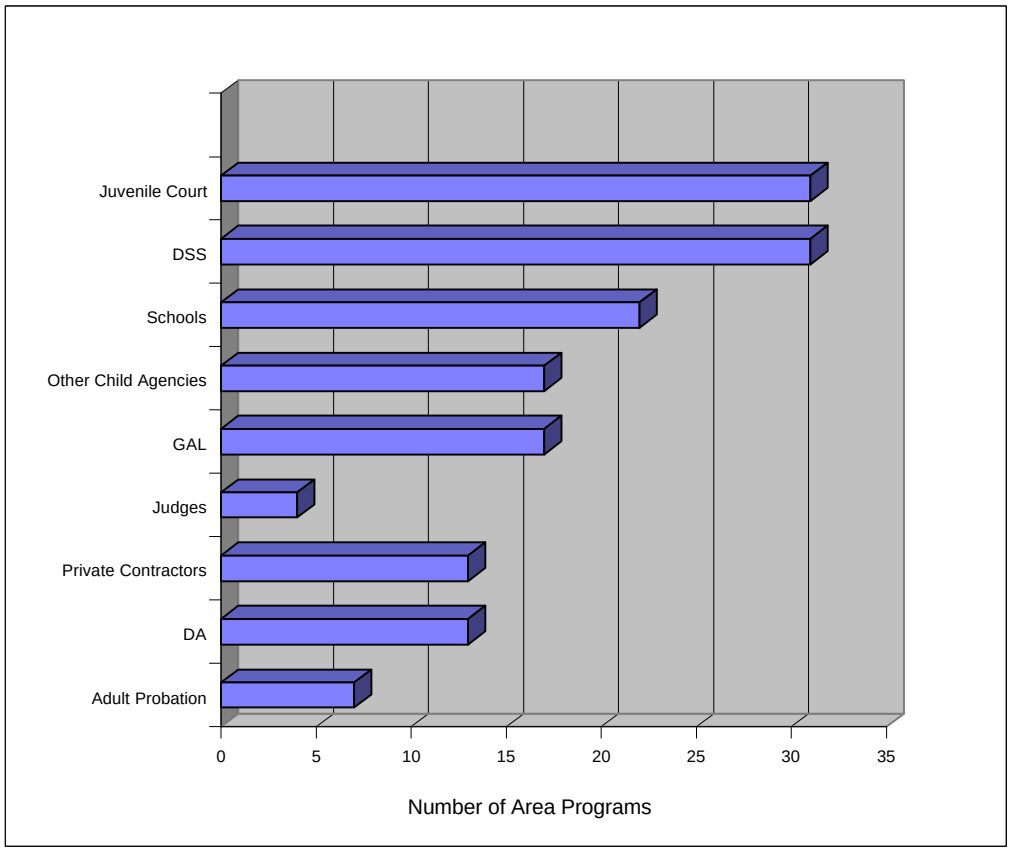
Community Team Involvement

Successful outcomes with youth and children who are sexually aggressive is contingent upon the provision of comprehensive treatment targeted to a broad range of needs.

Collaboration with other child serving agencies in the community is a critical component in this effort. Some Area Programs have community teams who meet regularly on behalf of the children and youth they serve. Community teams are comprised of representatives from, but not limited to, Area MH/DD/SAS Programs, the Division of Social Services, Juvenile Court, schools, Guardians Ad Litem, Judges and District Attorneys' offices. These teams meet on a regular basis to plan and coordinate services for the children and youth within their catchment area. Some Area Programs rely on convening a team that specifically is created for the particular child.

Thirty-one Area Programs report an active community team or close coordination of treatment and planning with Juvenile Court and the Department of Social Services. Figure 8 depicts cooperating agencies and the extent to which they are prevalent across the state in the planning and coordination of treatment for youth with sexually aggressive behavior problems.

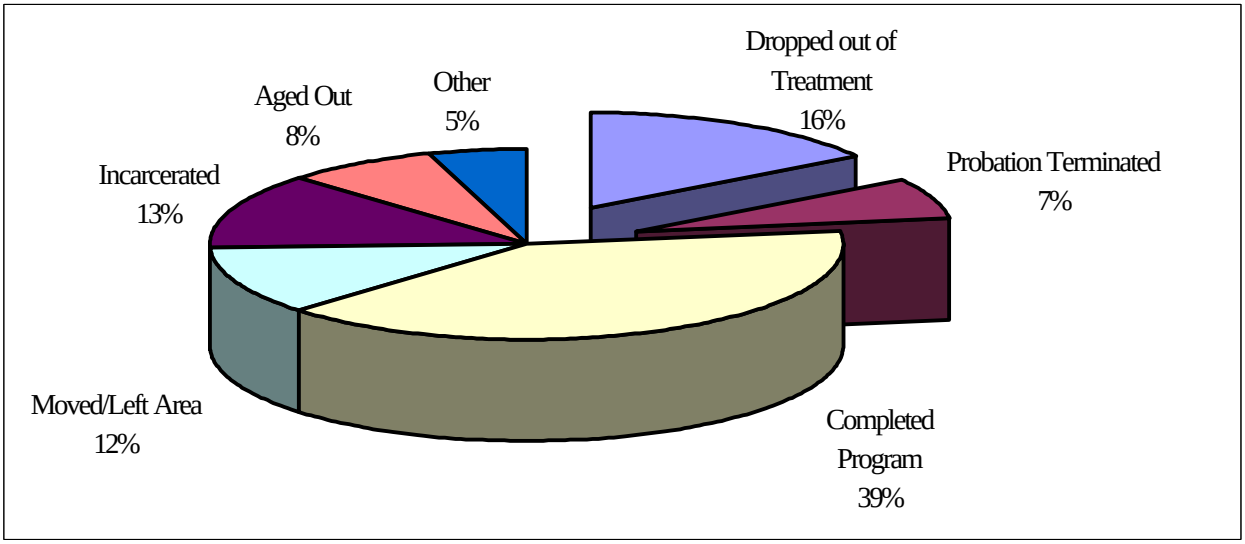
Figure 9. Community Team Participants



Reasons for Client Discharge from Treatment

The various reasons for client discharge from treatment are shown in Figure 9. The treatment outcome data shows that 39% of the youth discharged completed their treatment program; 61% of the population were discharged from treatment for various reasons without completing a program. Those clients who left treatment because probation was terminated (7%) and those who dropped out of treatment (16%) should be considered as prematurely terminating treatment. Many of the remaining 48% likely completed treatment successfully as youth or adults (for those who aged out); some of the youth transferred to new programs upon relocating in another geographical area; and some completed treatment during a period of incarceration. The Division of MH/DD/SAS recognizes the need to track client outcomes. An instrument recently was adopted to gather such data
on all clients within the Area Program system. This instrument will gather information on the sexually aggressive youth population as well.

Figure 10. Reasons for Client Discharge from Treatment



Child and Family Services Section Efforts to Develop Services

The role of the Child and Family Services Section of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services includes coordinating planning and program development efforts. For the sexually aggressive youth population, this is accomplished through statewide training and technical assistance. The Child and Family Services Section coordinates the activities of the Sexually Aggressive Youth Task Force. The Task Force is comprised of Area Program child mental health staff who work directly with this population and a representative from the Administrative Office of the Court. The Task Force was instrumental in the development of this survey, the development of a new treatment guide, the "Youth Who Hurt . . . Adults Who Care" orientation training materials, and planning for the statewide conferences. The members of the Task Force

also coordinate regional network meetings for practitioners and other individuals who are interested in providing services for Sexually Aggressive Youth. There is often representation from the training schools, juvenile court, and private providers at these meetings.

In March of 1998 and March of 1999, the Child and Family Services Section and Task Force coordinated two major training conferences. These conferences were attended by almost 600 professionals who treat, supervise, interact with, monitor and evaluate sexually aggressive youth.

Topic titles for these conferences included:

- Family and Community Influences on the Development of Sexually Aggressive Youth
- Building Partnerships: A Community Effort
- Risk Management: Preventing the Sexual Abuse of Children in Residential Settings
- Strength Based Assessments
- Unified Treatment Planning
- Multidisciplinary Roles in the Management and Treatment of Sexually Aggressive Youth
- Juvenile Justice Reform Act
- Sex Offender Treatment 101
- Drama Therapy as a Interactive Learning Tool in the Treatment of Youth with Sexual Aggression Problems
- Examination, Confrontation and Integration of Religious Belief Systems within Sexual Abuse
- Systematic Treatment of Families Who Abuse: The Crisis Opportunity of Sibling Sexual Abuse
- Reuniting Juvenile Offenders with Their Families
- Confronting the Juvenile Sex Offender: A Skills Demonstration

Aside from providing in-state conferences and the orientation training, the Child and Family Services Section also sponsored thirteen individuals from local communities to attend the National Conferences for the Association for the Treatment of Sexual Abusers (ATSA). These conferences highlighted the most recent research on sex offending assessment and treatment and also provided advanced clinical training regarding treatment techniques and protocols for youth with sexual aggression problems. The individuals who attended the conferences subsequently shared the information with others in North Carolina at their respective network meetings.

Recommendations

Issue 1: As supported by the survey (see page 8), **Residential Treatment** facilities are needed in North Carolina to meet the needs of youth with sexual aggression problems at differing levels of risk and with various clinical presentations, including offenders who also have developmental disabilities, offending youth who are also deaf, those with severe conduct disorders, those who themselves were victims of sexual abuse, females, and latency aged children (6-12 years of age). Youth with these different presentations will require a variety of group approaches to treatment.

> *Recommendation:* Establish a continuum of residential treatment specifically structured for sexually aggressive youth and children including: a.) Secure residential treatment centers in each of the four mental health regions of the State that specialize in treatment of the different presenting problems, b.) Moderate and high management group homes to meet non-secure residential treatment needs, and c.) Therapeutic homes for youth and children who need treatment in family settings but who can not be safely maintained in their natural family.

Issue 2: The Sexually Aggressive Youth Task Force recommends that **Training** be available for providers on an on-going basis. Treatment techniques that are specific to youth with sexual aggressive problems are not taught in Graduate Schools across the country. Becoming a specialized practitioner for these youth and children requires that the therapist learn from research, acquire a body of knowledge through their own reading, learn from supervisors, and learn through their own experience. This is a developing field. An understanding of effective approaches with this population is emerging, but it is a specialty still in its initial stages of development. Because of this, continued and ongoing practitioner training is especially crucial.

> *Recommendation*: The Child and Family Services Section of the Division of MH/DD/SAS should continue to emphasize training providers in all Area Programs of the State.

Issue 3: The Sexually Aggressive Youth Task Force recommends that the State require practitioners to meet a minimum standard of proven knowledge, experience, and proficiency in the assessment and treatment of youth with sexually aggressive behavior problems. Practitioners also need guidelines to use "best practices" in delivering services.

> *Recommendation 1* On a statewide basis, develop **credentialing** standards to be sure that those who are performing services for sexually aggressive youth are qualified to do so. The membership standards proposed by the Association for the Treatment of Sexual Abusers (ATSA) should be considered as a foundation for North Carolina's approach to credential practitioners.
>
> *Recommendation* 2: Develop **"best practice" guidelines** that would include, at least, guidelines that define the roles and complementary relationships among the various child serving agencies including Juvenile Justice, the Department of Social Services, and the schools. The guidelines would also outline recommended approaches to assessment, service planning, coordination of services, and delivery of effective services.

ATTACHMENT 1: SEXUALLY AGGRESSIVE YOUTH SURVEY

AREA MH/DD/SAS PROGRAM INFORMATION

1. Name of Area MH/DD/SAS Program:_____
2. Name of person completing this survey: _____
3. Job Title:_____
4. Phone Number: _____
5. Fax Number: _____
6. Date completed: _____

SEXUALLY AGGRESSIVE YOUTH DEMOGRAPHIC INFORMATION

A "person with a sexually aggressive behavior problem" or Sexually Aggressive Youth is defined as "an individual who: (a) admits to having committed an act of sexual abuse or has been adjudicated of an illegal sexual act AND (b) the inappropriate sexual behavior is a current focus of treatment". This survey is designed to collect data for **SFY97-98** which occurred from **July 1, 1997 through June 30, 1998**. Include in your count all Sexually Aggressive Youth identified during this time period.

7. Total number of Sexually Aggressive Youth treated: _____

8. Total number of Sex Offender Specific Evaluation (SOSE) conducted:_____

9. Total number of youth with sexual aggression problems who were adjudicated:_____

10. Total number sexually aggressive youth identified who were Developmentally Delayed (IQ is 70 or lower)_____

11. Total number youth with sexual aggression problems identified who were Deaf or Hard of Hearing:_____

12. Total number sexually aggressive youth identified with learning disabilities (Identified by participation in Exceptional Children's Program):_____

13. Total number youth with sexually aggressive behavior problems who are Willie M class members:_____

14. Please complete the following table for each category listed:

AGE	MALE	FEMALE	HIGH RISK	MOD. RISK	LOW RISK	WHITE	BLACK	Hisp	Other
AGE 0-7									
AGE 7-11									
AGE 12-16									
AGE 17-18									
TOTALS									

PLACEMENT

15. Indicate the number of sexually aggressive youth who were placed during treatment at each of the following:

At home _____
With relatives_____
DSS Foster Care_____
Therapeutic Foster Care_____

Group Home_____
Therapeutic Camping Program_____
High Mgt. Group Home_____
Residential Treatment Center_____
Hospital_____
Training School_____
Other_____(Please specify)_____

16. Please indicate the names & location of **group homes** your area program used for placement of youth with sexually aggressive behavior problems.

Name	Location	No. of Beds in the Grp. Home

17. Please indicate the **Residential Treatment Centers** your area program used to serve youth with sexually aggressive behavior problems.

Name	Location	Total No. of Beds Available

18. Please list the **hospitals** to which youth with sexual aggression problems were sent:

Name of Hospital	Location of Hospital

9. Please list **Training Schools** to which youth with sexual aggression problems were sent. (Upon doing a SOCE, or during the process of treatment, the client was sent to a training school):

Name	Location

20. Please list any **out-of-state facilities** your area program used for treatment and placement of youth with sexual aggression problems.

Name	Location

21. Total number of sexually aggressive youth who went unserved._____

22. Total number of sexually aggressive youth who went underserved._____

23. For the two groups of children mentioned in #21 and 22, provide the information requested in the following table:

Service the child received	Service the child should have received	Reason for the discrepancy in Columns 1 and 2.

IMPACT ON THE COMMUNITY

24. Total number of separate offenses reported by this group at assessment: _____

25. Total number of victims identified by this group at assessment: _____

26. Total number of **additional offenses** disclosed during treatment which were **not** identified prior to treatment beginning: _____

27. Total number of offenders who themselves were victims of sexual abuse:_____

INFORMATION ON SERVICE DELIVERY

28. Average **length of stay** stated in months in treatment for:

low risk offenders _____
moderate risk offenders_____
high risk offenders _____

29. Number of youth **discharged** from treatment because the youth:

_____completed program _____moved/left area ____dropped out of treatment

_____aged out _____was incarcerated ____probation terminated

_____other: (Please specify.)_____

30. Identify **all services** provided as a part of sexually aggressive youth treatment:

____Individual ____Family ____Outreach

____Case management ____Residential _____Therapeutic Homes

____SOSE ____In-Home ____ Psychological Evaluation

____Day Treatment ____CBI ____ Group

____Wrap-around ____Individual HRI _____Afterschool

____Court Liaison ____Screenings _____Supervision

____Crisis Intervention/Stabilization _____Other (please specify)

31. Identify the number of older youth with sexual aggression problems who were transitioned into ***adult*** services and for whom transitional services were appropriate and adequate._____

32. Identify the number of older youth with sexual aggression problems who were transitioned into ***adult*** services and for whom the transitional services were inappropriate and inadequate._____

33. Number of youth with sexual aggression problems with dual or multiple psychiatric diagnoses_____

34. Number of sexually aggressive youth groups conducted per week: _____

35. Average group size:_____

36. Give the age range in each of the groups: (For example: 7-11)

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6

37. Number of staff present when conducting groups:_____

38. If more than one staff is present, identify gender make-up of group leadership (Indicate the number of groups in each category.)

_____male/male;

_____male/female;

_____female/female

39. What theoretical group treatment model is used during group? (check all that apply):

_____relapse prevention_____cognitive behavioral _____psycho-ed

_____socialization _____anger management _____process group

_____other_____

SYSTEM OF CARE INFORMATION

40. Does your area program make use of a system of community management/treatment teams in treatment of sexually aggressive youth?_____

41. Identify active participants in your community management / treatment teams for youth with sexual aggression problems. (Check all that apply.)

_____DSS _____juvenile court _____adult probation

_____DA _____schools _____private contractors

_____judges _____GAL _____other child serving agencies

42. Number of youth with sexual aggression behavior problems served who were Medicaid eligible: _____

43. Number of youth with sexual aggression behavior problems served who were **not** Medicaid eligible: _____

(Answer numbers 44-46 if you are able to supply the information.)

44. How much state, local, federal and third party funding was devoted to sexually aggressive youth

SFY '97 - '98?

$_____	$_____	$_____	$_____	$_____
state	local	federal	third party	total

45. Identify how the funding was distributed by percentages to all that apply.

_____training / staff development _____center provided services

_____contract services _____other:_____

46. Identify total dollars spent for sexually aggressive youth services by pioneer category:

$_____24 hour $_____day/night $_____periodic

STAFF INFORMATION

47. Identify number of staff who participated in the sexually aggressive youth networks at each level:

_____Regional _____State _____National _____International

48. Total number of staff who attended annual State sponsored sexually aggressive youth conference on Mar. 30 and 31, 1998._____

49. Identify number of Staff members with specialized training to conduct SOSE's: _____

50. Please indicate the information requested relative to your sexually aggressive youth staff.

Name of Practitioner	**Professional Designation**	**Trained to conduct SOSE**: ***Yes or No***	**Hours per week spent**

51. Identify any barriers to providing effective treatment for youth with sexual aggression behavior problems. Please **rank order** the barriers with number 1 being the most pressing barrier to effective treatment. (Use reverse side as needed.)

1._____
_____

2._____
_____

3._____
_____

4._____
_____

ATTACHMENT 2: SERVICE DEFINITIONS

After School: After-school activities would promote and assist in the development of the skills, behaviors and responsibilities needed to function successfully by providing the client support and monitoring in his/her home or other places in the community.

Case Management: The service is designed to meet the educational, vocational, residential, health, financial, social and other non-treatment needs of the individual. The service includes the arrangement, linkage or integration of multiple services (when provided by multiple providers) as they are needed or being received by the individual either with the Area Program or from other agencies.

Client Behavior Intervention (CBI): This service includes promoting and assisting in the development of the skills, behaviors and responsibilities needed to function successfully. CBI includes providing training and assistance with activities of daily living; providing monitoring and support of the client during periods of symptom exacerbation; assisting in the development of insight into the process of relapse or decompensation and the development of motivation and skills that will increase access to community resources.

Court Liaison: This is the process by which a mental health or other trained professional provides information to the court regarding a client's involvement in treatment. A court representative may also provide the same service.

Crisis Intervention: The therapeutic practice of helping clients in crisis to promote effective coping that can lead to positive growth and change by acknowledging the problem, recognizing its impact, and learning new or more effective behaviors for coming with similar predictable experiences.

Day Treatment: Provides day/night service for children and adolescents who are emotionally disturbed which coordinates educational activities and intensive treatment while allowing the individual to live at home or in the community.

Family Therapy: Intervention by a professional social worker or other family therapist with a group of family members who are considered to be a single unit of attention. It seeks to clarify roles and reciprocal obligations to encourage more adaptable behaviors among the family members.

Group Therapy: An intervention strategy for helping individuals who have emotional disorders or social maladjustment problems by bringing together two or more individuals under the direction of a trained professional. The individuals share problems with the group, discuss ways to resolve them, and share emotional experiences in a controlled setting that enables the members to work through their difficulties.

In Home: This service is delivered in the client's home and could be family preservation, client behavior intervention (CBI), outpatient treatment or individual high risk intervention (HRI).

Individual Therapy: A specialized, formal interaction between a trained mental health professional and an individual in which a therapeutic relationship is established to help resolve symptoms associated with mental illness, psycho-social stress, relationship problems and difficulties in coping in the social environment.

Individual High Risk Intervention (HRI): This service includes early treatment, psycho-educational, recreational activities designed to intervene in or reduce disability or dysfunction. This service also includes education/training services to the primary caregivers (e.g. family members, teachers). Although similar to CBI, HRI requires more highly trained staff.

Outreach: The service includes activities, with and/or on behalf of an individual in need who is not registered as a client. The service is designed to meet some of the evaluation, treatment, habilitation, educational, vocational, residential, health, financial, social and other needs of the individual.

Psychological Evaluation: Use of standardized tests to identify personality characteristics and behavior profiles relevant to the therapeutic treatment process.

Residential: Therapeutic intervention processes for people who cannot or do not function satisfactorily in their own homes. This 24 hour service includes a significant amount of individualized therapeutic or rehabilitative programming.

Screenings: This is an assessment service which provides for an appraisal of an individual who is not a client, in order to determine the nature of the individual's problem and his/her need for services.

SOSE: A Sex Offender Specific Evaluation or SOSE is an extensive evaluation used to gain important background information regarding the youth's inappropriate sexual behavior, evaluate the general dangerousness of the youth and estimate the risk of re-offending. This evaluation is used to ascertain any threat the youth may pose to the community and to provide recommendations to the court regarding treatment and placement.

Supervision: An administrative and educational process used extensively in social agencies to help social workers further develop and refine their skills and to provide quality assurance for the clients.

Wrap-around: This refers to the process of providing (or wrapping around) several services to a client in order to provide a successful step-down from a more restrictive setting or to alleviate the need for more intensive services. This service is very similar to Individual HRI or CBI and, oftentimes, the terms are used interchangeably.

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